Report to the Legislature

Chemical Dependency Disposition Alternative

Chapter 338, Laws of 1997, Section 27
RCW 13.40.165 and 70.96A.520

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Chemical Dependency Disposition Alternative:

Annual Report to the Washington State Legislature

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Executive Summary

The Chemical Dependency Disposition Alternative (CDDA) codified in RCW 13.40.165, became effective July 1, 1998. This disposition alternative provides local juvenile courts with a sentencing option for chemically dependent youth, allowing judges to order youth into treatment instead of confinement. RCW 70.96A.520 requires that:

> *"The department shall prioritize expenditures for treatment provided under RCW 13.40.165. The department shall provide funds for inpatient and outpatient treatment providers that are the most successful, using the standards developed by the University of Washington under section 27, Chapter 338, Laws of 1997." In addition, " the department shall, not later than January 1 of each year, provide a report to the Governor and the Legislature on the success rates of programs funded under this section."*

To comply with this legislation, an outcome evaluation is being conducted to support the annual reports to the Governor and Legislature. The current report describes the results from the 6- and 12-month evaluation of the CDDA program. The final report containing the 18-month outcome data will be presented in the January 2004 report to the Governor and Legislature.

The CDDA outcome evaluation compares recidivism, substance abuse, and other measures of success between CDDA-sanctioned, non-CDDA-sanctioned, and Drug Court youth. Outcomes are compared at 3, 6, 12, and 18 months from the date CDDA eligibility is determined. Recruitment for the CDDA outcome evaluation occurred between January 1999 and June 2001. A total of 403 youth from 8 counties were recruited into the outcome evaluation. Of these youth, 165 were in CDDA, 53 were in a Drug Court, and 185 were in neither CDDA nor Drug Court. The study is not a treatment versus no treatment study since 68 percent of youth in the Comparison group received some substance abuse treatment services.

Results from the 6- and 12- month assessment revealed that:

- Youth in all three groups demonstrated significant decreases in the number of different types of drugs used, use of marijuana, and truancy.

- Youth in CDDA and Drug Court received more intensive treatment services than youth in the Comparison group.

- Committable youth in CDDA had better outcomes than those not in CDDA. Committable youth in CDDA:
  - were less likely to be incarcerated
  - were detained fewer days
  - used fewer types of drugs
  - used less marijuana
  - were more likely to be enrolled in school or to have graduated from school or to have earned a GED

- Locally sanctioned youth in CDDA and Drug Court were less likely to be incarcerated than locally sanctioned youth not in CDDA or Drug Court.

- Further study, with longer follow-up periods on the differences between committable and locally sanctioned youth, youth in CDDA and Drug Court, and youth receiving treatment compared to those receiving no treatment is needed to determine the optimal means of treating juvenile offenders with substance use problems.

I. Introduction

Chapter 338, Laws of 1997, created the Chemical Dependency Disposition Alternative (CDDA) and became effective July 1, 1998. The CDDA legislation was codified in RCW 13.40.165. This disposition alternative provides local juvenile courts with a sentencing option for chemically dependent youth, allowing judges to order youth into treatment instead of confinement. The Department of Social and Health Services' Juvenile Rehabilitation Administration (JRA), in collaboration with the department's Division of Alcohol and Substance Abuse (DASA), was given the responsibility of designing and implementing the program.

This legislation also required the University of Washington (UW) to develop standards for measuring the treatment effectiveness of CDDA. These standards were developed by the UW's Alcohol and Drug Abuse Institute (ADAI) and presented in the 1997 report entitled ***Effectiveness Standards for the Treatment of Chemical Dependency in Juvenile Offenders: A Review of The Literature*** submitted to the Legislature on January 1, 1998. These effectiveness standards are used to determine the efficacy of the CDDA program on an annual basis as required by RCW 70.96A.520.

CDDA represents a collaboration of JRA, local juvenile courts, and DASA's interests in using community-based programs as an alternative to detention, as well as the Legislature's interest in providing sentencing alternatives for chemically dependent juveniles. CDDA also represents a union of juvenile court-administered services and county-coordinated drug and alcohol treatment systems. CDDA provides local communities with a monetary incentive to implement interventions for juvenile offenders that research demonstrates to be effective in reducing substance use among chemically dependent youth. In providing chemically dependent juvenile offenders with effective treatments, substance use should decrease, as should involvement in criminal behaviors. CDDA should not only reduce the state's costs of incarceration for juveniles, but also provide a cost-effective means of improving the overall functioning of a juvenile while keeping him or her within the local community.

This report describes information gathered from the six- and twelve-month assessments in the CDDA outcome evaluation. Descriptions of each county's CDDA program and unique features of these programs are provided in Appendices 1, 2, and 3.

II. Implementation of CDDA to Date

Although CDDA became available to all juveniles committing crimes after July 1, 1998, processing requirements of local juvenile courts delayed juveniles from entering CDDA until as late as November 1998.

Figure 1 (page 7) presents the steps that occur in determining whether a youth will be placed in CDDA or not. To be eligible for the CDDA program, a youth must:

- be between 13 and 17 years of age,

- not have current A- or B+ charges,
- be chemically dependent or a substance abuser, and
- not pose a threat to community safety.

Currently, all 33 juvenile courts have developed CDDA programs. At least eight counties access Title 19 matching funds to increase fiscal resources for CDDA.

III. CDDA Evaluation Overview

Legislation associated with CDDA requires that:

> *"…the department shall prioritize expenditures for treatment provided under RCW 13.40.165. The department shall provide funds for inpatient and outpatient treatment providers that are the most successful, using the standards developed by the University of Washington under section 27, chapter 338, Laws of 1997. The department may consider variations between the nature of the programs provided and clients served, but must provide funds first for those that demonstrate the greatest success in treatment within categories of treatment and the nature of persons receiving treatment."*

The ability of the outcome evaluation to document statistically that one treatment provider is more effective than another is severely limited for several reasons. There are four treatment modalities utilized in CDDA, each of which has numerous providers: 1) detention-based outpatient; 2) inpatient; 3) intensive outpatient; and 4) standard outpatient. The number of juveniles treated by each provider is, therefore, relatively small. There is also wide variation in the services being provided within each treatment modality (e.g., one inpatient program provides family education, another provides family meetings, another family therapy).

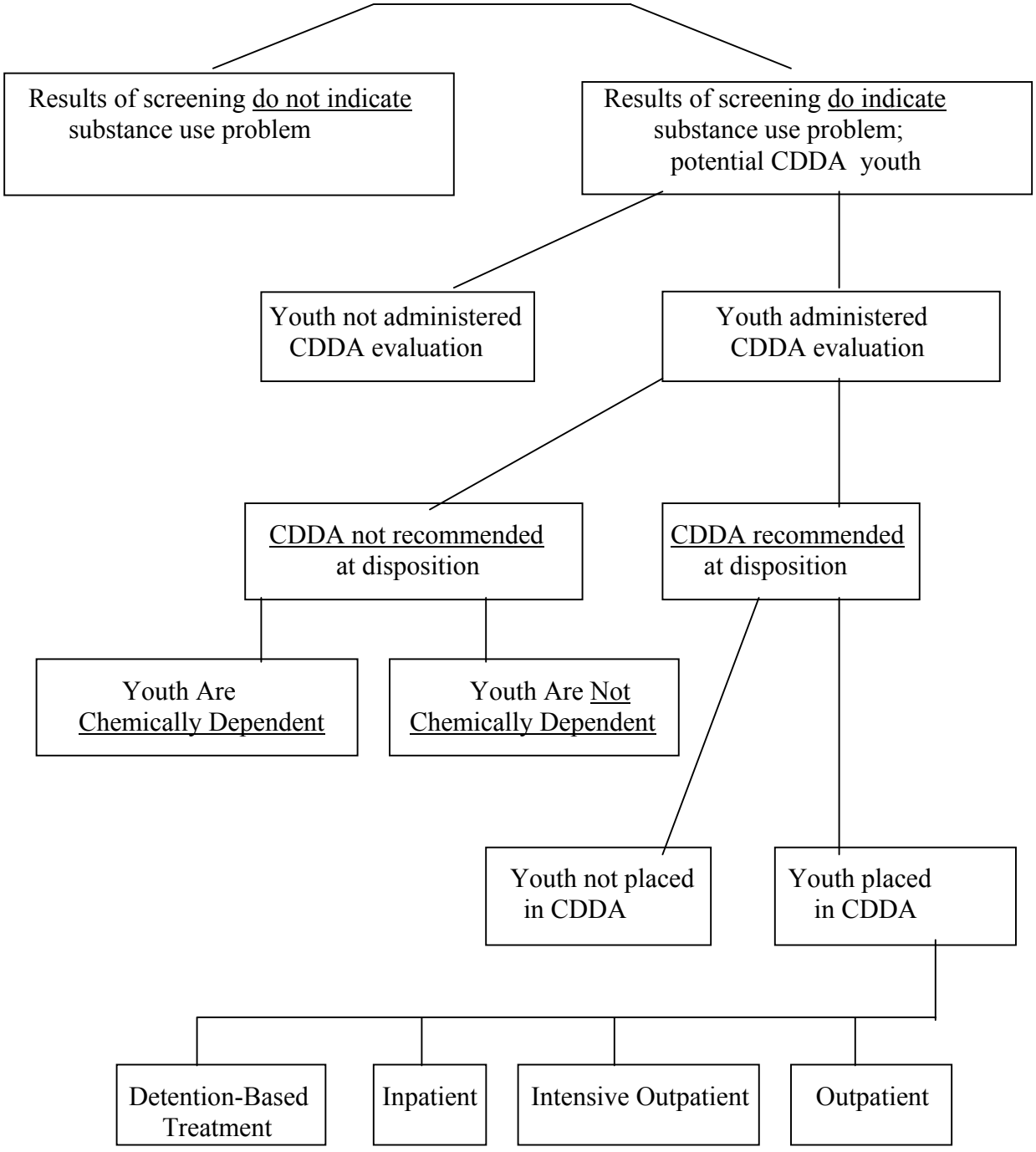
These factors make it impossible to make statistically meaningful comparisons of individual treatment provider outcomes. The outcome evaluation is able to describe the aggregate outcomes of juveniles treated across the various treatment modalities and indicate which configuration of services relates to the most positive outcomes for locally sanctioned and committable juveniles based on measurement of the effectiveness standards.

The outcome evaluation is being conducted in eight counties. Counties were chosen based on their size, how inclusive the county's CDDA model was of the elements of effective treatment included in the ***"1997 Effectiveness Standards"*** report, and by geographic location. The eight counties involved in the CDDA outcome evaluation are:

Benton/Franklin	Kitsap	Spokane
Clark	Pierce	Yakima
King	Snohomish	

Figure 1

Juvenile Court Procedures for Determining CDDA Eligibility



The CDDA outcome evaluation was designed to compare results of assessments of substance use, criminal activity, and functioning in several important domains of life (e.g., family, social, and school). Comparisons are made on these factors between youth receiving CDDA services and other youth that were eligible for CDDA, but did not participate in CDDA. These comparisons are made at baseline (which is when youth were assessed to determine clinical eligibility for CDDA), and again 3, 6, 12, and 18 months from the date of the initial assessment. Youth from the CDDA and comparison group are followed for the entire 18-month study period, without regard to their CDDA status.

The effectiveness standards that are used to measure outcomes of the groups are:

- reduced criminal recidivism as defined, under a legislative directive, by the Washington State Institute for Public Policy as:
  - reduced criminal convictions and/or incarceration

- reduced substance use as evidenced by a reduction in:
  - the total number of days of substance use
  - the number of re-admissions to a chemical dependency treatment program (e.g., detox, inpatient, or outpatient)
  - number of emergency room visits or inpatient medical hospitalizations

- improved school performance as evidenced by:
  - an improvement in grades
  - a decrease in truancy or dropout

- improved family functioning as evidenced by:
  - fewer conflicts with family members
  - decreased runaway episodes

- improved social functioning as evidenced by:
  - less time spent with substance-using and/or delinquent peers
  - increased friendships with non-substance using peers

- improved psychological functioning as evidenced by:
  - fewer days of self-reported mood disorders
  - fewer admissions for psychiatric treatment, either inpatient or outpatient

These standards are evaluated through repeated administrations (3, 6, 12 and 18 months) of a standardized assessment, the Adolescent Drug Abuse Diagnoses interview, and review of treatment and criminal records at each follow-up point.

It should be noted that youth in the Comparison group might have received some substance abuse treatment services. The duration and intensity of services received, however, would not be as great as the services received by youth in CDDA. Thus the Comparison group should not be thought of as a “no treatment” group.

IV. Outcome Evaluation

A. Current Status of CDDA Outcome Evaluation

As mentioned earlier, recruitment of youth for the CDDA Outcome Evaluation was conducted in eight counties between January 1999 and June 2001. A total of 403 youth were recruited into the study.

CDDA was originally designed to provide committable chemically dependent youth supervised substance abuse treatment services as an alternative to JRA confinement. Committable youth are defined as those youth eligible for 15-36 weeks of confinement in a JRA facility. The majority of youth being evaluated and entering CDDA have, however, been "locally sanctioned" youth. Locally sanctioned youth are defined as those youth eligible for 0-30 days in detention and up to 12 months of community supervision.

The number of committable youth recruited into the study was comparatively small (N=81) compared to locally sanctioned youth (N= 322). This difference reflects the relative number of committable and locally sanctioned statewide referrals to CDDA.

Table 1 provides information on the number of youth recruited in each of the eight participating counties. In addition, 53 youth were recruited into this study that entered a Drug Court Program in King (N= 21), Kitsap (N= 14) or Snohomish County (N= 18).

Like CDDA, Drug Court is a 12-month long supervision program that incorporates substance abuse treatment. Unlike CDDA, Drug Court provides locally sanctioned youth the strong incentives of dismissing the current charge and the ability to retain one's driver's license if the program is successfully completed.

Table 1

Youth Recruited By County

	Committable			Locally Sanctioned		
	CDDA	Non-CDDA	Total	CDDA	Non-CDDA	Total
Benton/Franklin	1	2	3	3	2	5
Clark	7	9	16	11	0	11
King	2	4	6	13	10	23
Kitsap	4	0	4	10	7	17
Pierce	9	4	13	25	15	40
Snohomish	2	7	9	58	33	91
Spokane	3	13	16	5	58	63
Yakima	5	4	9	8	16	24
Total	33	43	76	133	141	274

Another difference between Drug Court and CDDA is that youth in Drug Court meet regularly with a "Drug Court Team," which includes the Juvenile Court Judge as a member, to review their progress. Despite the fact that the number of Drug Court youth is small relative to the CDDA and Comparison groups, it is sufficient enough to allow for comparisons to be made between youth in CDDA, Drug Court, or in neither CDDA nor Drug Court (Comparison group).

Baseline, 3-, 6- and 12-month interviews have been completed. The 18-month interviews will all be completed by January 2003. This report presents data from the completed baseline, 6- and 12-month assessments. Follow-up rates for all interviews exceeded 85% (6-month 89.1%, 12-month 86.4%, and 18-month 85.6%). Data from the baseline, 6- and 12-month assessments were obtained for 84.4% of the sample. That data was utilized for the following analyses of substance use and other outcomes.

1. Demographic Variables

Youth recruited into this outcome evaluation are primarily Caucasian males aged 15.6 years old. No significant differences were found between CDDA and the Comparison group on any demographic variable (Table 2). Analyses revealed no significant differences in the number of past hospitalizations or outpatient treatments for medical, psychological, or substance abuse problems between the two groups. Youth in each group averaged less than one past episode for each of these treatments.

There were no significant differences on any of the demographic variables presented in Table 2 between committable youth in CDDA and committable youth in the Comparison group. The only significant differences found between locally sanctioned youth in CDDA and the Comparison group was that more of the CDDA youth had a working head of household (84.5 percent versus 73.9 percent).

TABLE 2				
Demographic Comparisons of 165 CDDA, 53 Drug Court and 185 Comparison Youth				
				F or X^2
Variable	CDDA	Drug Court	Comparison	Value
Age	15.6	15.8	15.7	0.6
% Caucasian	75.3	83.3	75.7	1.6
% African American	8.6	5.6	7.3	0.6
% Hispanic	8.4	0	10.7	6.9*
% Native American	5.6	5.6	4.0	0.5
% Asian	1.9	5.6	1.1	4.1
% Male	77.8	81.5	77.8	0.4
# of People Living in Home	4.2	3.8	4.2	1.3
% Living With Both Parents	21.0	25.9	12.4	7.0*
% Living With Mother Alone	33.3	25.9	30.5	1.1
% Living With Father Alone	4.9	11.1	5.6	2.8
% Head of Household Currently Employed	83.2	85.2	72.5	7.2*
# Times Ran Away	3.2	2.3	4.9	3.2
% Ever Homeless	19.8	9.3	24.9	6.3*
% Ever in Foster Care	21.9	9.8	29.6	9.0**
				*p<.05, **p<.01

Youth in Drug Court were significantly less likely to be Hispanic, and more likely to be living with both parents, at least one of which was currently employed, compared to CDDA or Comparison group youth. Drug Court youth were also less likely than CDDA or Comparison youth to have been homeless or to have lived in foster care in the past.

2. Treatment Activities

Youth in CDDA are expected to receive enhanced substance abuse treatment services (See Appendix 1). Service enhancements should include increased case management, counseling services, family involvement in treatment, and greater use of urine drug screens. Moreover, while not all youth will require a year of treatment services, these

services should be available for at least a year if needed by youth. Youth in Drug Court are expected to receive similar treatment enhancements.

This study is not a treatment versus no treatment study as the majority (68 percent) of youth in the Comparison group received some substance abuse treatment services. The intensity and duration of services received, however, were significantly less than those received by youth in CDDA or Drug Court.

Table 3 provides information from DASA's Treatment and Assessment Report Generation Tool (TARGET) database on the average number of days youth in CDDA and the Comparison group spent in each treatment modality over the 12-month period. With the exceptions of recovery house and group care enhancements, youth in CDDA spent significantly more time in each modality of treatment compared to Comparison youth.

Table 3

Average Number of Days of Treatment For the 12-Month Study Period

	CDDA	Drug Court	Comparison	F-Value
Treatment Modality	N= 163	N =53	N=185	
Inpatient	15.0	11.9	4.2	8.8***
Intensive Outpatient	45.6	57.8	10.8	13.3***
Standard Outpatient	70.8	125.9	23.5	29.4***
Recovery House	2.6	1.8	0.6	1.9
Group Care Enhancement	1.2	0.7	5.7	1.8
				***p<.001

Evaluation of time spent in treatment between committable youth in CDDA and the Comparison group revealed a similar pattern. Committable youth in CDDA spent significantly more time in all types of treatment except intensive outpatient, recovery house, and group care enhancements than committable youth not in CDDA.

Youth in CDDA spent significantly more time in inpatient treatment, but less time in standard outpatient treatment than youth in Drug Court. Information presented in previous annual reports indicates that CDDA youth were recommended for inpatient treatment more often than youth in Drug Court. Additionally, fewer youth in CDDA were assigned to outpatient treatment compared to youth in Drug Court. Hence, youth in CDDA would be expected to spend more time in inpatient treatment and less time in outpatient treatment compared to youth in Drug Court.

While in treatment during the 12-month period, CDDA youth received significantly more of all types of services than did Comparison youth (Table 4). Youth in Drug Court received significantly more of all types of services compared to youth in the Comparison group. Youth in CDDA received less individual counseling and case

management services, and fewer urine drug screens than Drug Court youth. This difference may result from youth in CDDA having spent less time in outpatient treatment compared to youth in Drug Court.

Table 4

Treatment Activities For the 12-Month Study Period

	CDDA	Drug Court	Comparison	F-Value
Treatment Activity	N= 165	N =53	N=185	
Conjoint with Family	0.8	1.2	0.1	7.2***
Family Without Client	1.0	1.5	0	7.1***
Individual	6.9	17.4	2.3	19.8***
Group	41.9	40.9	7.1	16.5***
Case Management	5.3	28.5	1.7	40.6***
Urine Drug Screens	6.8	13.9	0.6	25.8***

***p<.001

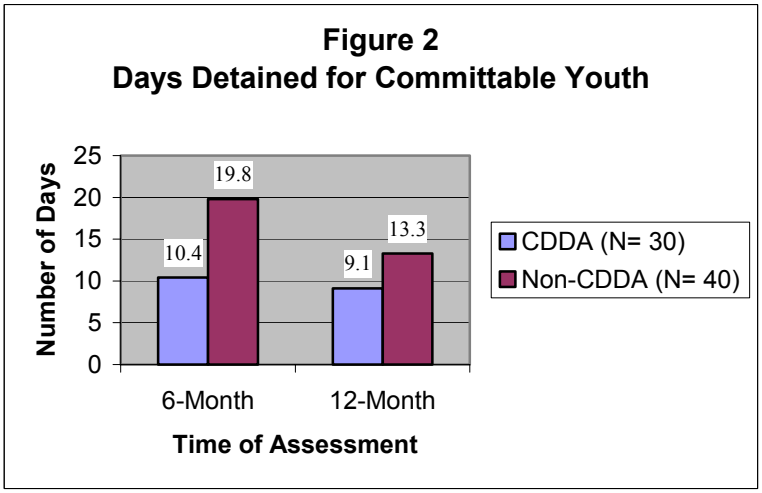
Although it was recommended that families be involved in all phases of treatment for CDDA, it appears that few treatment programs involved families or provided family therapy for youth in CDDA. The majority of substance abuse treatment programs do not have family therapists on staff. CDDA does not supply sufficient fiscal resources to enable treatment providers to employee family therapists. Therefore, existing programs that do not employ family therapists were not able to provide family therapy services to CDDA youth. This explains why the number of family therapy services provided to youth in CDDA was low.

B. Committable Youth—Assessment Results

Of study youth that were committable, 33 were placed in CDDA, 43 received standard probation services, and 5 entered a Drug Court. The number of committable youth in Drug Court does not allow for meaningful statistical comparisons so they were excluded from the following analyses.

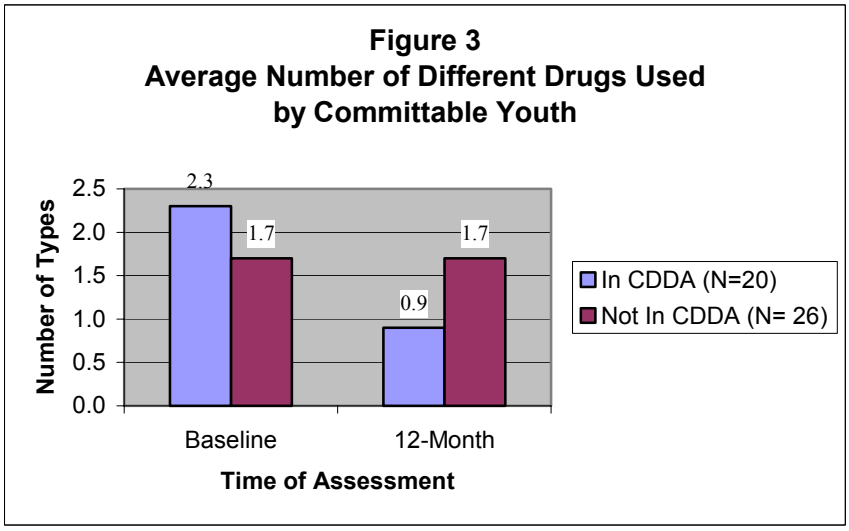
1. Criminal Behavior

Analysis of JUVIS records revealed no significant difference in the number of prior lifetime convictions between committable CDDA and Comparison youth. Significantly fewer committable youth in CDDA were incarcerated at both the 6- and 12-month assessment compared to those not in CDDA (22.7 percent versus 45.1 percent). Committable youth in CDDA had also spent fewer days detained in the time preceding the 6 and 12-month assessments compared to committable youth in the Comparison group (Figure 2).



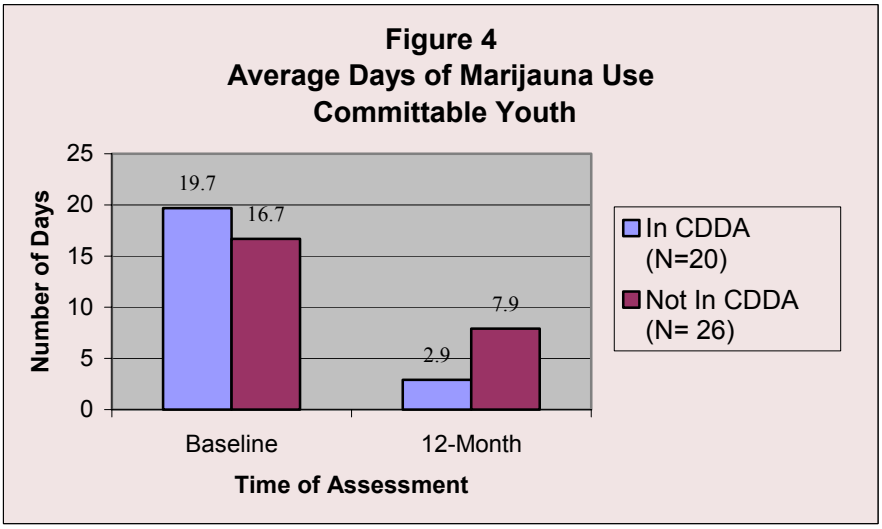
2. Substance Use

Youth in the study are users of predominately marijuana (89.4 percent), alcohol (80.0 percent), and tobacco (73.3 percent). Use of amphetamines was reported by 28.2 percent of the sample, 24.2 percent reported use of hallucinogens. Use of other types of drugs (e.g., cocaine, inhalants) was reported by less than 10 percent of youth in the sample at baseline. Initial use of amphetamines, cocaine, and hallucinogens was less than four days a month. For all youth, use of these drugs decreased to less than 1 day a month over the 12-month period. Since relatively few youth were using these substances, and levels of use were low, analyses regarding reductions in substance use focus on marijuana and alcohol use. In the following analyses, Figure 3, youth incarcerated at both assessment points were removed from analyses since they did not have access to drugs or alcohol.



CDDA committable youth were using significantly fewer different types of drugs at the 12-month assessment compared to Comparison youth (Figure 3). As seen in

Figure 4, use of marijuana at the 12-month assessment was significantly lower for committable youth in CDDA compared to committable youth not in CDDA. No difference in use of alcohol between the groups was discovered.



3. School Performance

CDDA positively impacted school performance. Although truancy decreased significantly over time for all youth from an average of 4.9 days a month initially to 0.31 days at the 12-month assessment, committable youth in CDDA were significantly more likely than the Comparison group to have graduated from school or to have earned a GED by the time of the 12-month assessment (16.7 percent versus 7.0 percent).

4. Social Functioning

CDDA appeared to be effective in encouraging the establishment of more positive peer relationships. At the 12-month assessment, fewer committable youth in CDDA reported spending "a lot of time" with drug-using peers than those not in CDDA (15 percent versus 26.1 percent). Moreover, significantly more committable CDDA youth reported spending "a lot of time" with drug-free peers (40.9 percent versus 7.7 percent) at the 12-month interview.

5. Family Functioning

There were no significant differences in the number of times that a youth ran away during the 12-month study period between CDDA and non-CDDA committable youth. Nor were any significant differences revealed between the two groups in the percentage of youth reporting "fights or arguments" with family members over the 12

month study period. These results are not surprising given that very few youth in CDDA received any form of family therapy.

6. Psychological Functioning

No significant differences between CDDA and non-CDDA youth were found in the number of days of psychological problems (i.e., depression, anxiety, impulse control) reported in the previous month at either the 6- or the 12-month assessment. Youth typically reported an average of 8 days of problems at the 6-month assessment and 9 days of distress at the 12-month assessment. The average number of admissions to inpatient or outpatient treatment for psychological problems was less than one for youth in both groups.

C. Locally Sanctioned Youth—Assessment Results

The following section provides comparisons of outcomes for locally sanctioned youth that are in CDDA (N= 133), standard probation services (Comparison group N = 143) or a Drug Court (N = 48).

1. Criminal Behavior

Analysis of JUVIS records revealed no significant differences in the number of prior lifetime convictions between CDDA and Comparison youth. Drug Court youth did have significantly fewer past convictions (3.7) compared to CDDA (5.2) or Comparison youth (5.5).

As found with committable youth, CDDA appears to be effective in reducing the percent of locally sanctioned youth that are convicted and incarcerated. Only 6.5 percent of CDDA youth were incarcerated at both the 6- and 12-month assessment compared to 14.1 percent of Comparison youth and 7.0 percent of Drug Court youth.

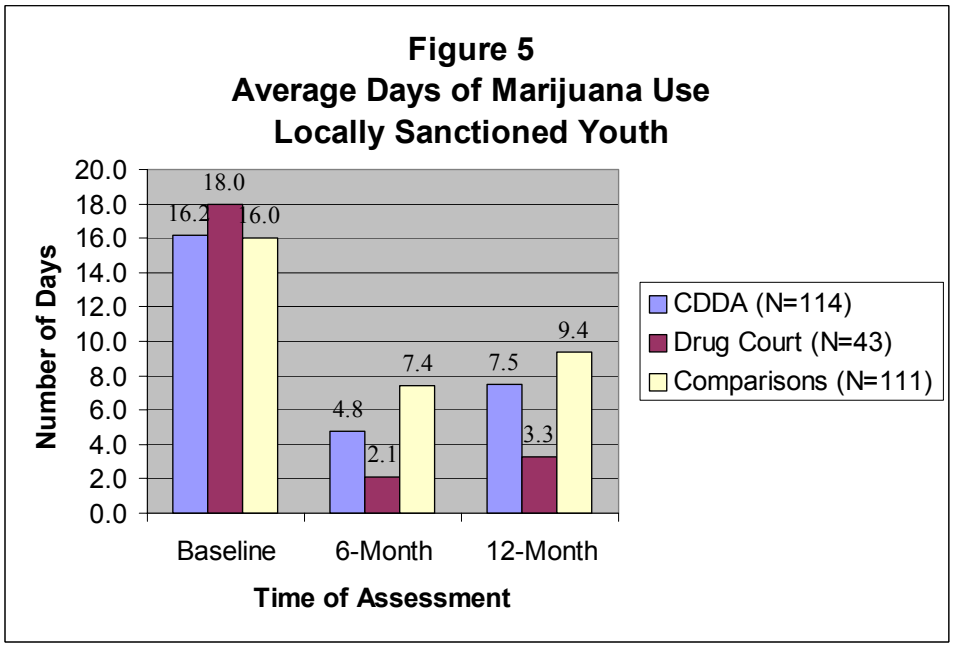
At the six-month assessment there was not a significant difference between the three groups in the average number of days that a youth was detained (approximately five days). At the 12-month assessment, youth in CDDA and the Comparison group had been detained approximately the same number of days in the previous six months (5.3), but youth in Drug Court spent significantly fewer days detained compared to youth in CDDA or the Comparison group (2.4 days).

2. Substance Use

There were no significant differences between the three groups of locally sanctioned youth in the number of types of drugs used at any point in time. The number of types of drugs used significantly decreased over time for all youth.

After removing youth incarcerated at both assessments from the sample, analyses revealed that youth in CDDA used significantly less marijuana at the 6-month

assessment than Comparison youth (Figure 5), but did not use significantly less marijuana at the 12-month assessment. Drug Court youth reported significantly less use of marijuana than Comparison youth at the two follow-ups, but their level of use was only significantly lower than that reported by CDDA youth at the 12-month follow up.



Use of alcohol increased slightly but not significantly for all groups between the 6- and 12-month assessments. Increased alcohol use at the 12-month followup may, in part, be an effect of the increasing age of youth in the sample. Alcohol becomes more accessible as youth age.

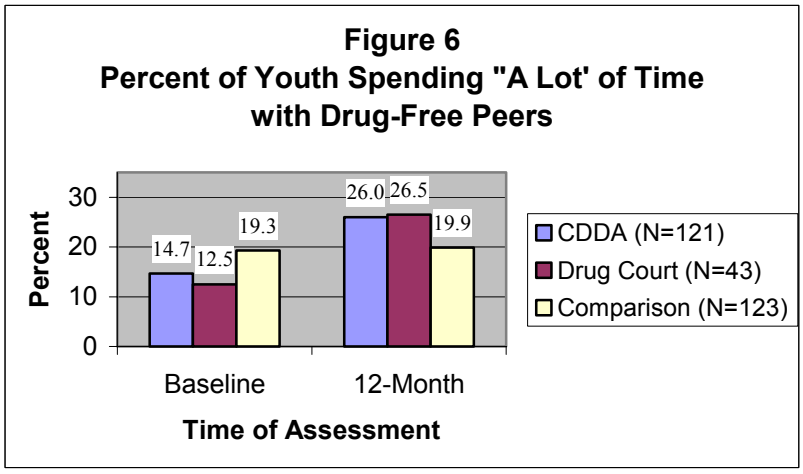
3. School Performance

Truancy decreased significantly over time for all youth from 3.8 days initially to 0.61 days at the 12-month assessment. No difference between the three groups in the number of youth that were currently enrolled or had graduated or earned a GED at either of the assessments was found for locally sanctioned youth.

4. Social Functioning

No statistically significant differences between groups of locally sanctioned youth were found on any variable assessing social functioning at the 6- or 12-month assessment. Despite the lack of statistical significance, considerably more youth in CDDA and Drug Court increased the amount of time that they spent with drug-free

friends over the study period while the percentage remained stable for youth in the Comparison group (Figure 6).



5. Family Functioning

As found with committable youth, no significant group differences were revealed between groups with respect to family functioning. As mentioned previously, the lack of family therapy provided to youth in CDDA may, in part, explain these findings.

6. Psychological Functioning

No significant differences between youth in the three groups were found in the number of past inpatient or outpatient treatments for emotional problems. There were no significant differences revealed between groups in the number of days of psychological problems (i.e., depression, anxiety, impulse control) reported in the previous month at either the 6- or the 12-month assessment.

V. Summary

This study should not be viewed as a treatment versus no treatment study since 68 percent of youth in the Comparison received some treatment services over the 12-month study period. The duration and intensity of the services received by youth in CDDA (committable and locally sanctioned) and Drug Court were, however, significantly greater than services received by youth in the Comparison group.

Results from the 6- and 12-month assessments showed that youth in all three groups showed decreases in the number of different types of drugs used, marijuana use, and truancy over the 12-month period. Findings provide several indications that the combination of enhanced

treatment services and legal supervision provided by CDDA and Drug Court resulted in significantly better outcomes for committable and locally sanctioned youth.

A key component of the CDDA program design was provision of family therapy services to all participants. While CDDA has been successful in increasing substance abuse treatment services provided, this has not been the case with respect to family therapy services. Recent research from the Washington Institute on Public Policy (*2002 Report on Functional Family Therapy*) finds that providing functional family therapy to juvenile offenders significantly reduces criminal recidivism. Although the CDDA program has resulted in significant improvements, providing family therapy services may greatly enhance the outcomes of participants and result in improved family relationships, an area that is not currently demonstrating improvement. Without additional fiscal resources, however, service agencies involved with CDDA will be unable to provide family therapy to CDDA participants.

Alcohol use was not significantly reduced by participation in CDDA (committable or locally sanctioned) or Drug Court. Slight increases in alcohol use may be related, in part, to the increased age of the youth. Alcohol becomes more available to youth as they age. Urine drug screens are administered randomly to youth in CDDA and Drug Court, but tests such as breathalyzers are generally not administered in these programs. Instituting random administration of tests for alcohol consumption in CDDA and Drug Court may promote reductions in youths' alcohol use.

CDDA was designed for committable, not locally sanctioned youth. Results suggest that committable youth in CDDA had better outcomes than locally sanctioned youth. The incentive for participation in the 12-month program for committable youth was the avoidance of institutionalization for an extended period of time. Locally sanctioned youth that fail to complete CDDA may be detained in the community for up to 30 days and may be placed on longer legal supervision, but locally sanctioned youth do not face the possibility of long-term institutionalization. The fact that locally sanctioned youth, unlike committable youth, do not have such severe legal consequences as an incentive for successful participation in CDDA may explain the differential impact of CDDA on committable and locally sanctioned youth. Few other significant differences were evident between committable and locally sanctioned youth in CDDA that could account for the different response to CDDA.

The differential response to CDDA of committable and locally sanctioned youth does not appear to be related to any differences in relevant demographic variables, criminal history, severity of substance use, or the treatment services received. Committable youth in CDDA were slightly older (16.0) than locally sanctioned youth in CDDA (15.5), but did not differ on any other demographic variable examined. Although there was not a significant difference in the percentage of youth that were chemically dependent, committable youth in CDDA reported using marijuana for a significantly longer period of time than locally sanctioned youth (42.4 months versus 33.3 months, $p<.05$). Committable youth in CDDA did not have significantly more past convictions compared to locally sanctioned youth in CDDA (3.0 versus 2.6 respectively). The only significant difference found regarding services received by committable and locally sanctioned youth was that committable youth

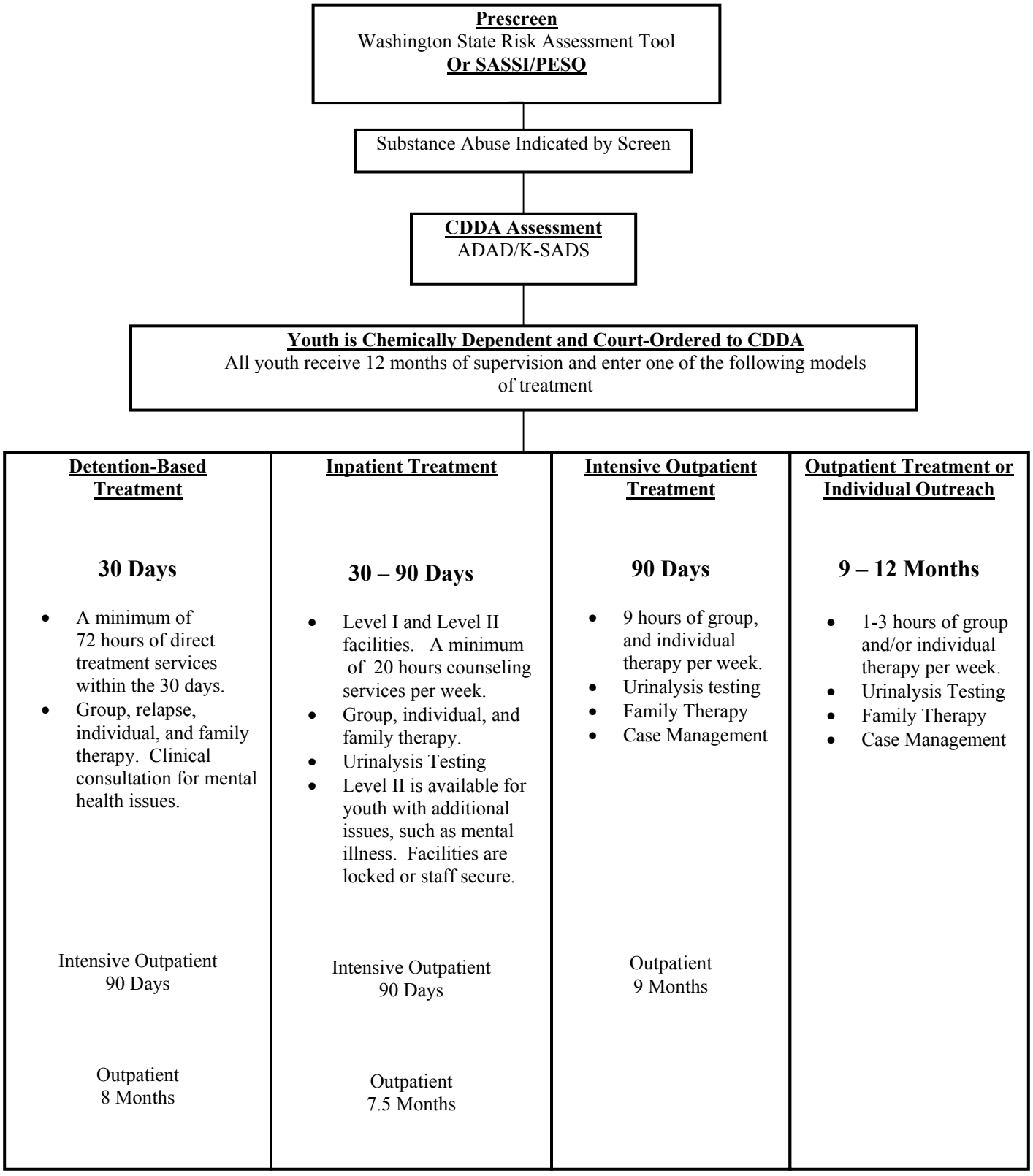
in CDDA spent less time in intensive outpatient treatment compared to locally sanctioned youth in CDDA (16.1 days versus 52.8 days, $p<.05$).

In summary, findings from this study indicate that provision of increased substance abuse treatment services and legal supervision reduces negative behaviors of youth. The effectiveness of CDDA, however, would be further enhanced by inclusion of additional services, specifically family therapy. Juvenile courts should be encouraged to use CDDA as an option for committable youth with substance use problems, as results of this study provide several indications that committable youth in particular benefited from participation in CDDA.

Further study on the differences between committable and locally sanctioned youth, the CDDA and Drug Court programs, and treatment versus no treatment are necessary to fully understand what types of treatment result in optimal outcomes for committable and locally sanctioned juvenile offenders with substance use problems.

Appendices

Appendix 1
CDDA Treatment Model



Appendix 2

Current Treatment Models by County

All treatment programs include a combination of increased supervision by juvenile courts, a case manager, a family services component, and a combination of the treatment modalities listed below. Inpatient treatment services are available to all county courts.

Detention-Based Treatment:	Clallam, Clark, Columbia/Walla Walla, Kitsap, Kittitas (tied to Yakima), Okanogan, Pierce, Thurston, and Yakima
Intensive Outpatient Treatment:	Adams, Asotin/Garfield, Benton/Franklin, Chelan, Clallam, Columbia/Walla Walla, Cowlitz, Douglas, Ferry/Stevens/Pend Oreille, Grays Harbor, Island, Jefferson, King, Kitsap, Lewis, Mason, Okanogan, Pacific/Wahkiakum, Pierce, Skagit, Snohomish, Spokane, Thurston, Whatcom, Whitman, and Yakima.
Community-Based Outpatient Treatment:	Benton/Franklin, Clallam, Clark, Ferry/Stevens/ Pend Oreille, Island, Lincoln, Snohomish, Pierce, and Yakima

Appendix 3

Description of Requirements for CDDA Treatment Modalities

Inpatient Treatment

- Level I and Level II provide a minimum of 20 hours of counseling services per week in accordance with WAC 440-22-410.
- Services shall include individual, group, and family services.
- Level II treatment is available for youth with issues in addition to chemical dependency such as mental health issues. The facilities contracted for CDDA are locked or staff secure.

Detention-Based Outpatient Treatment

- A minimum of 72 hours of direct treatment services within the 30 days.
- Treatment components would include: chemical dependency group counseling, education, family counseling and/or family issues group counseling, relapse prevention planning and counseling, individual counseling, case management, and continuing care planning.
- Clinical consultation to address mental health and other clinical complications.

Intensive Outpatient Treatment

- A minimum of 3 hours of group counseling a week.
- 1 hour of individual counseling a week.
- 1 hour of case management advocacy a week.
- Weekly urinalysis.
- Family services (family therapy and or parent training).

Outpatient Treatment

- 1 hour of support group a week.
- 1 hour of individual counseling a week.
- Family services (Family Therapy and/or Parent Training/Support).
- 1 hour of case management advocacy/week.
- Urinalysis (weekly).

Individualized Outreach

- 1-2 hour of individual counseling a week.
- Family services (Family Therapy and/or Parent Training/Support).
- 1 hour of case management advocacy/week.
- Urinalysis (weekly).

Appendix 4

TIMELINE FOR CDDA EVALUATION

Date	July-Dec	Jan-June	July-Dec	Jan-June	July-Dec	Jan-June	July-Dec	Jan-June
	1999	2000	2000	2001	2001	2002	2002	2003
CDDA Project Month	13-18	19-24	25-30	31-36	37-42	43-48	49-54	55-60
Recruitment and Baseline Assessment								
12 Months of CDDA Treatment								
3-Month Follow-up								
6-Month Follow-up								
12-Month Follow-up								
18-Month Follow-up								
Data Analysis								